Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEDICAL EQUIPMENT DEVICE SPECIALISTS
7950 DUNNBROOK RD
SAN DIEGO CA 92126

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

LIBERTY INSURANCE CORP

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-11-3636-01

MFDR Date Received

JUNE 20, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Specifically, in January 2011, we received bulk denials on every Liberty Mutual patient of our which contains the same exact denials. The denial code is xe20, a homegrown code from Liberty Mutual, which contains three different denial reasons. Since there was no indication which of the three was the actual reason for the denial, we have spent months inquiring in order to ascertain the specific reason, so that we may properly appeal, and/or make sure that the proper statute was satisfied in accordance with the denial by the carrier. (i.e. if there was a denial for medical necessity that a proper peer review was done so that we could file for an IRO.) Liberty Mutual has failed to respond as to why every patient falls under xe20, and failed to identify which of the tree denial reasons was the applicable one for each respective patient that was denied."

Supplemental Response dated July 14, 2001 [sic]: Enclosed are photocopies of portions of the current edition of the Official Disability Guidelines – Treatment in Workers' Comp which evidence that the durable medical equipment provided by Medical Equipment Device Specialists is specifically addressed therein and, therefore, the Division treatment guidelines or Division treatment protocols. As a result, Texas Administrative Code Rule §134.600 (p)(12), cited by Liberty Mutual, is inapplicable. This regulation section requires preauthorization **only** for treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan pre-authorized by the carrier. Since the durable medical equipment provided falls within ODG this regulation, by its terms, is inapposite."

Amount in Dispute: $1,210.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Attached is a copy of Rule 133.307 which explains timely filing requirements for the Medical Dispute Resolution Process. A request for dispute resolution must be received by the Division within one year of the date of service. This dispute was received on June 20, 2011 therefore dates of service prior to June 20, 2010 are not eligible for MDR. A copy of the ODG guidelines regarding diagnosis 440 is also attached. The bill for purchase of the unit was on 3/18/10 and was denied as not within the guidelines of the ODG which have been adopted for use by the Division. The remaining charges in dispute are for supplies and conductive garments for use with the denied unit. DME charges in dispute were denied because they are outside the ODG and the required

preauthorization was not requested. Rule 137.100(d) relates to a carriers responsibility for reimbursement of treatments or services."

Response Submitted by: Liberty Mutual Insurance, 2875 Browns Bridge Road, Gainesville, GA 30501

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 18, 2010 through June 23, 2010	HCPCS Codes E1399 and A4595	$ 706.00	$0.00
July 23, 2010 through January 23, 2011	HCPCS Codes A4595	$504.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).
4. 28 Texas Administrative Code §137.100 sets out the procedures for health care under the treatment guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 17, 2010, October 11, 2010, October 22, 2010, November 17, 2010, December 29, 2010, January 13, 2011, and February 2, 2011
   - B15 - This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.
   - XE20 – There services were delivered for a non-authorized DME device. The DME provider failed to obtain pre-authorization or the DME device was deemed in appropriate for the work related injury. By extension all related supplies lack the requisite authorization as well and are not separately reimbursable.

Issues

1. Are all dates of service listed on the Table of Disputed Services in dispute?
2. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.307?
3. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
4. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. Dates of service July 26, 2010 and July 26, 2010 show an amount in dispute of $0.00; therefore, these dates of service will not be reviewed.
2. In accordance with §133.307(c)(1)(A) requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the division. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute. Subparagraph (B)(ii) states that a request may be filed later than one year after the date(s) of service if a medical dispute regarding medical necessity has been filed, the medical fee dispute must be filed not later than 60 days after the date the requestor received the final decision on medical necessity, inclusive of all appeals, related to the health care in dispute and for which the

carrier previously denied payment based on medical necessity. Dates of service May 21, 2010, May 26, 2010 and June 26, 2010 were not received within one year after the dates of service in dispute. Therefore, these dates of service are not eligible for review.

3. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution.

   In accordance with 28 Texas Administrative Code §137.100 The insurance carrier is not liable for the costs of treatments or services provided in excess of the Division treatment guidelines unless: (1) the treatment(s) or service(s) were provided in a medical emergency; or (2) the treatment(s) or service(s) were preauthorized in accordance with §134.600 or §137.300 of this title. Review of the submitted documentation finds that the insurance carrier denied the services per the Official Disability Guidelines. According to subparagraph (e) an insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonable required. According to 28 Texas Administrative Code §137.100(f) states that a health care provider that proposes treatments and services which exceed, or are not included, in the treatment guidelines may be required to obtain preauthorization in accordance with §134.600 of this title. Review of the documentation submitted by the requestor did not support the services rendered complied with the Official Disability Guidelines and confirms that preauthorization was not requested for the services billed. Documentation was not submitted to support that the issues of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution.

   The Official Disability Guidelines, adopted by the Texas Department of Insurance/Division of Workers' Compensation, is diagnosis driven. The requestor submitted Procedure Summaries for shoulder, pain, low back, knee and elbow from the ODG to support the TENS/NMES was listed as a treatment in the ODG. While TENS/NMES may be a treatment for certain diagnoses, the diagnosis code for the compensable injury in this dispute is 550.9 - Inguinal hernia without mention of obstruction or gangrene, unilateral or unspecified. Review of the ODG treatment guidelines for Hernia does not address TENS/NMES as a possible treatment. Therefore, the requestor did not support their position.

4. The requestor has failed to support that the services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning medical necessity have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		February 8, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.